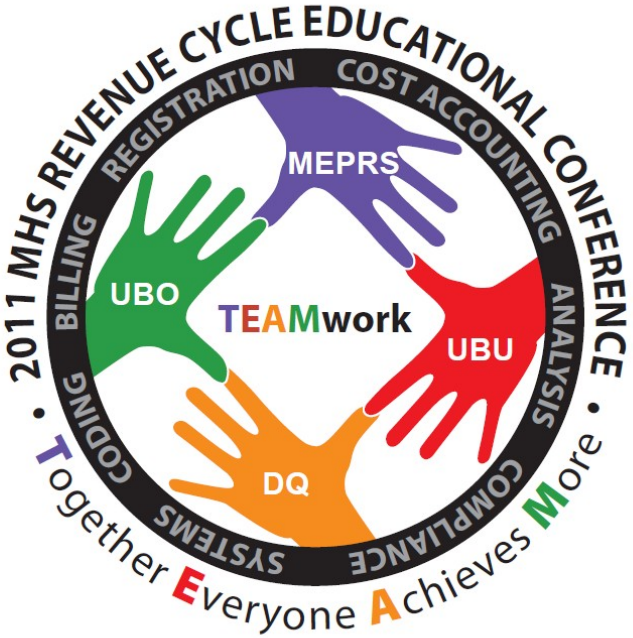


Title: **Observation Coding**

Session: **T-6-1330**

Objectives

- Review highlights of the most recent Health Affairs policy update regarding Observation (OBS) services
- Increase knowledge by reviewing MHS coding guidance
  - Expand on fundamentals of OBS status, documentation, and time requirements
  - Identify locations and related clinical pathways
  - Practice coding professional and facility services using various scenarios
- Be aware of other clinical scenarios that can intersect OBS
- Appreciate the importance of supporting your Business Office in identifying and billing OBS services

MHS Observation Care Policy Updated

- New Health Affairs memorandum in place as of August 2010
  - Replaces March 1999 interim policy
  - Specifies two locations in the MTF where OBS can occur; on the nursing unit/ward or in the Emergency Department (ED)
  - Requires administrative “admission” in CHCS when OBS occurs on the nursing unit/ward
  - Eliminates the need for the B**0 MEPRS
- While not a perfect solution from a coding and billing perspective, the volume of patients is small
  - Continuity of patient care is of primary importance
  - Updated MHS OBS coding guidance published in January 2011 as Appendix H

Defining Observation Status

- "The use of a bed for physician periodic monitoring and active monitoring by the hospital's nursing or other ancillary staff, for the patient's care and for services that are reasonable and necessary to evaluate an outpatient's condition or determine the need for an inpatient admission." (https://www.highmarkmedicareservices.com)
  - Clinical determination usually made within 24 hrs; although can sometimes span two or even three calendar dates
- Observation is an outpatient hospital status; not inpatient
  - Despite "admission" inpatient classification in CHCS, and
  - Creation of a SIDR if OBS occurs on the ward
- Only bedded facilities can perform OBS services

OBS Status Must Be Consistently Identified

- Most OBS occurs on the ward; the administrative admit in CHCS will generate incorrect inpatient claims and interagency invoices; requires manual billing intervention
- Skews accurate inpatient census data and population health metrics without unique MHS coding strategy
- System infrastructure limits CHCS disposition status types
- For OBS on the ward, code all outpatient OBS services on the associated ADM Rounds in SADR/CAPER
- For ED OBS, code all services on the ED SADR

Locations Authorized to Provide OBS Services

- On the nursing unit/ward
  - Most OBS services likely occur in this setting
  - Requires special attention from inpatient coders to understand MHS-unique sequencing rules regarding first- or last-listed diagnosis code of V71.9
  - Actual OBS services will be captured on the “A***” Rounds SADR
    - E/M services of “observing” provider, plus
    - G0378 (and G0379 when applicable) to capture facility hours of observation
- In the Emergency Department (ED)
  - Uses the ED’s MEPRS code
  - Capture ED and OBS services on same SADR
  - Separate medical record required for OBS services documentation

MHS Data Reveals OBS Location Variances

- 2009 and prior data MHS-wide showed observation E/M codes used in:
  - B*** MEPRS (lots of GYN)
  - B**5, 6 MEPRS (APVs)
  - ED MEPRS (Ok, but separate medical record?)
  - B**0 (Observation MEPRS code, now extinct)
- In 2011, only BIAA and A*** MEPRS should reflect observation coding

Services Not Qualified for Observation Status

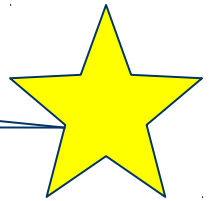
- Observation services for the convenience of the patient or others are not medically necessary and don’t qualify
- Routine pre- or post-operative services related to an Ambulatory Procedure Visit
- Planned overnight stays after APV surgery
- Concurrent OBS care with other outpatient encounters like chemotherapy, radiation therapy, or dialysis
- Standing orders of any kind for outpatient or maternity services requesting or defining OBS status

Observation Status – Yes or No?

- An elderly patient is scheduled for an outpatient surgery. While an overnight stay is not typically necessary for this surgery, the patient is requesting that he be allowed to stay overnight. The surgery is successful with no complications. The patient stays overnight in observation.
- Sarah is scheduled to have cataract surgery in the APU. Her surgery is performed at 9:00 a.m. She goes to recovery at 9:45 a.m. She has difficulty in recovery with some cardiac problems. Her physician decides to place her in OBS on the ward at 11 a.m. At 6:00 p.m. she has completely recovered and is asymptomatic. She is discharged and sent home with her daughter.

The Need for Privileged Provider Orders

- Physician must order OBS *specifically*
  - They can have the concept of Inpatient Observation due to location
  - Suggest establishing standard notations for orders. Examples:
    - "Admit to observation"
    - "Admit to observation unit"
    - "Place patient into observation status"
    - "Pt. to OBS"



- If subsequently "admitted" as an inpatient, documentation that clearly defines the status change is necessary
  - Suggest physician's order contain words "admit" and "inpatient"
  - Progress notes should support the need for acute care
- There should be no "automatic admission" criteria or orders

Separate OBS Medical Record Required

- It's stated in the Health Affairs policy
- Medical record creation, filing, type of record needs to be addressed
- For OBS in the ED, a separate record must be created and maintained in addition to the ED encounter documentation
- For OBS on the ward, a separate OBS record must be created
  - For OBS status converted to inpatient, logic dictates that the same record should not be applicable to OP and IP status
  - Medical Records policy consideration: OBS as an EAR record?

Observation CPT Codes

* Codes	99218 99219 99220	99234 99235 99236	99224 99225 99226	99217
Description	Initial Observation Care For Services **NOT** Starting and Ending on the Same Date	**Observation** (or Inpatient Care Services) For Services **Starting and Ending on the Same Date**	Interval Day Observation Care **New codes in 2011**	Observation Care Discharge Services
Select code from above when:	Placed under observation with discharge on a different date	Placed under observation and discharged on the same date –	For dates patient is neither placed into or discharged from OBS status	Discharge services are performed and documented in the OBS record
Comments	All E/M services rendered by the "observing" physician are coded separately in the ED	Do not also code a discharge day service of 99217	Physician must see and examine the patient	Physician must see and examine the patient

Initial Observation E/M: 99218-99220

CPT Code	Code Description	Criteria For Use
99218	Initial observation care, per day, for the evaluation and management of a patient. Usually, the problem(s) requiring admission to "observation status" are of low severity.	Requires these 3 key components: detailed or comprehensive history; detailed or comprehensive examination; and medical decision making is straightforward or of low complexity.
99219	Initial observation care, per day, for the evaluation and management of a patient. Usually, the problem(s) requiring admission to "observation status" are of moderate severity.	Requires these 3 key components: comprehensive history; comprehensive examination; medical decision making of moderate complexity.
99220	Initial observation care, per day, for the evaluation and management of a patient. Usually, the problem(s) requiring admission to "observation status" are of high severity.	Requires these 3 key components: comprehensive history; comprehensive examination; and medical decision making of high complexity.

- Per CPT, only the provider who is listed as the physician of record can report the initial observation E/M code
- Documentation must include the following four components:
  - Notation that the patient was placed in “observation status”
  - Notations of periodic patient reassessments
  - A discharge from observation evaluation
  - A post-discharge from observation care plan

Discharge from Observation: 99217

CPT Code	Code Description	Criteria For Use
99217	Observation care discharge day management	-Utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." -Documentation should support that the provider was personally present and performing this service.

- Per CPT, coding of the discharge from observation "…is to be utilized by the physician to report all services provided to a patient on discharge from "observation status…."
- In order to code, there should be personal documentation by the "observing" provider indicating their presence and face-to-face services were provided

Same Day Observation E/M: 99234 – 99236

CPT Code	Code Description	Criteria For Use
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date. Usually the presenting problem(s) requiring admission are of low severity.	-Requires these 3 key components: detailed or comprehensive history; detailed or comprehensive examination; medical decision making that is straightforward or of low complexity. -Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date. Usually the presenting problem(s) requiring admission are of moderate severity.	-Requires these 3 key components: comprehensive history; comprehensive examination; medical decision making of moderate complexity. -Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date. Usually the presenting problem(s) requiring admission are of high severity.	-Requires these 3 key components: comprehensive history; comprehensive examination; medical decision making of high complexity. -Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

- Medical record must clearly state that the patient is in “observation status” and clearly indicate that the patient was “observed” and “discharged from observation”
- History, Examination, & Medical Decision Making MUST be met for EACH of these three levels!

Subsequent "Interval" OBS Care: 99224 – 99226

CPT Code	Code Description	Criteria For Use
99224 *new 2011 CPT code	Subsequent observation care, per day, for the evaluation and management of a patient. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.	Requires at least 2 of these 3 key components: problem focused interval history; problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
99225 *new 2011 CPT code	Subsequent observation care, per day, for the evaluation and management of a patient. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.	Requires at least 2 of these 3 key components: expanded problem focused interval history; expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
99226 *new 2011 CPT code	Subsequent observation care, per day, for the evaluation and management of a patient. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.	Requires at least 2 of these 3 key components: detailed interval history; detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

- Once the new 2011 code range above is available in the various MHS information systems, these codes will be used to report such "intervening days" for service dates effective in 2011
- Until the codes above are available, use E/M codes 99211-99215 for interval day observation E/M services

Observation HCPCS Codes

Codes	G0378	G0379
Description	Hospital observation service, per hour	Direct referral for hospital observation care
Select code from above when:	Coding total OBS time, per day: 1.When rendered on the Ward, code total hours per day on each Rounds SADR 2.When rendered in the ED, code the total hours for the entire episode of care on the ED SADR	1. The patient bypasses the MTF clinic or ED. 2. Code with the Units of Service entered as one (1) on the FIRST day only in OBS status.
Comments	1. Coding the G0378 on the SADR captures the facility charges 2. Determining total time under OBS care is addressed in detail on subsequent slides 3. The code is sequenced after the physician's E/M code(s) with the appropriate number of hours in the Units of Service field	1. Often called a "community" referral since the patient bypasses the MTF clinic or ED 2. Code is captured once on the first day in OBS status on the SADR record 3. This code would not be used in the ED setting

- Code G0378 *In addition to* the observation care E/M CPT code documented by the physician
- Used to report the total number of hours a patient is in observation status for facility/institutional billing
- Code G0379 on the ward when bypassing MTF

Calculating Observation Status Time

- OBS status time begins at the clock time appearing on the nurse's initial observation status "admission" or status note
- OBS time ends at the clock time documented in the attending privileged provider's "discharge"/release orders
- If there is no time on the attending privileged provider's discharge/release orders, the time the nurse signs off on the attending privileged provider's orders shall be used
- AND, technically, OBS time should not include concurrent time diagnostic or therapeutic services were provided for which active monitoring is a part of the procedure (e.g., colonoscopy)

Properly Documenting Time in OBS

- In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour)
- Try your best to discern services that are performed concurrently with OBS and deduct that time from the total hours reported for facility OBS services
- A total of 31+ minutes is rounded up to the next unit

Questions & Answers, Then Back at 1430

- Any questions so far?
  - Today's special: Deer-in-the-headlight blank stares are free
- The next section will delve into:
  - Clinical pathway considerations
    - Coding OBS services in the ED
    - Coding OBS services on the nursing unit/ward
    - When OBS status changes to admission
    - Coding OBS services on the Inpatient SIDR
  - Disposition status on the SADRs
  - Separate OBS medical record creation, storage, documentation
  - Example of OBS documentation template
  - Other clinical scenarios intersecting OBS services
  - Supporting Business Office functions and teaming up together

Clinical Pathways Identified

MHS Code Guide Appendix H Ref. #	Pathway	Code OBS Provider Services on:	Code G0378 Facility OBS hours on:	Code G0379 Facility OBS hours on:	V71.9 listed FIRST on the SIDR	V71.9 listed LAST on the SIDR
7, 7.1, 7.2	1. OBS on Ward → Home	"A" Rounds	"A" Rounds	"A" Rounds	Yes	No
8, 8.1	2. OBS in ED → Home	"B" SADR	"B" SADR	N/A	N/A	No
9, 9.1, 9.2	3. OBS on Ward → Inpatient status, or	"A" Rounds	"A" Rounds	"A" Rounds	No	Yes
9, 9.1, 9.2	3. OBS in ED → Inpatient status	ED "B" SADR	ED "B" SADR	N/A	No	No

- Three "clinical pathways" were identified that define typical observation origins and outcomes
- Sections 7, 8, and 9 in the MHS Coding Guidance serve to aid in determining the applicable E/M codes based on the documentation, location, and length of stay while in an outpatient OBS status setting

When OBS Begins and Ends Without Admission

- "Clinical Pathway 1":
  - ED or Clinic → Ward → Discharge to Home from OBS
    - Coding of the attending provider's OBS E/M depends on documentation for each date, whereas
    - Coding of the G0378 HCPCS code on the same "A" Rounds record is entered for the total facility observation time documented for each date that the patient is in observation status
- Inpatient coders will identify OBS services and sequence V71.9 as the first-listed position on the SIDR; generates the DRG 951; CCE flag occurs
- Admissions staff is requested to use V71.9 as the admitting diagnosis – please get the word to them

Clinical Pathway 1 Examples

- Patient seen in Internal Medicine clinic in MTF with complaints of shortness of breath and dizziness. The provider orders the patient into observation status on the nursing unit. Additional workup determines no need for admission to inpatient and patient is discharged home after 40 hours of observation spanning 3 calendar days.
- A maternity patient at 37 weeks gestation is experiencing epigastric pain and occasional contractions. She is seen in the ED and subsequently placed in observation status on the ward. After 4 hours in observation care, patient is diagnosed with reflux and false labor and is discharged home.

Clinical Pathway 1 Examples to Code

Length of Stay	99234 -99236 Admit/ Discharge same calendar day-OBS or IP E/M	99218 - 99220 Admit to OBS	99217 Discharge from OBS	99224 -99226 Subsequent interval day - OBS E/M	G0378 Facility OBS - per hour	V71.9 Sequenced first on the SIDR
1 Calendar Date- Admit & Discharge same day →					# _____	Yes
2 Calendar Dates- Discharge on Day 2 →					# _____	
3 Calendar Dates- Discharge on Day 3 →					# _____	

- The ED or clinic encounter preceding the order for Observation status should be coded and closed out with a Disposition Type of "Admitted" on the "B" CAPER.
- Provider must document orders for patient to be placed in "observation status."
-Patient will be given a Disposition Type of "Continued Stay" (on the "A" Rounds ADM record).
- Code the appropriate observation E/M service.
- Code any separately reportable outpatient CPT procedures.
- Also code the HCPCS Level II code G0378 *Hospital observation service, per hour* with the appropriate units of service to report the total number of hours the patient was in observation status for a given day (e.g., G0378 with a quantity of 12 for a twelve-hour observation stay).

OBS Services in the ED

- "Clinical Pathway 2":
  - ED Encounter → ED OBS → Discharge to Home from ED OBS
    - The ED is the other approved location where OBS status can be initiated.
    - The provider must write an order to place the patient under "observation."
    - A separate observation record must be documented in addition to the ED record.
      - Contains dated and timed provider's admitting orders, hours of observation reported as "units of service," nursing notes, and progress notes prepared by the provider
- Usually, only one encounter is generated for an episode of care in the ED.

Why OBS in the ED?

- When a patient requires E/M beyond that encompassed by the ED service. For example:
  - Diagnostic uncertainty – when a more definitive diagnosis could determine inpatient admission or discharge to home
  - Therapeutic intervention – when extensive therapy has a reasonable possibility of improving a patient's presenting condition, and thereby prevent a hospital admission
- Presenting conditions that may benefit from ED OBS
  - Abdominal Pain / Chest Pain
  - Apparent Intoxication
  - Asthma
  - Dehydration
  - Drug ingestion/Overdose
  - Renal Calculi
  - Syncope

Clinical Pathway 2 Examples

- The ED physician orders ED OBS services for a patient with a head injury. The observation occurs in the ED and a separate record is created for this care. Prior to being placed in observation status, the physician repairs a scalp laceration in the ED. Code the laceration repair and append Modifier 25 to the observation code.
- The ED physician orders ED OBS for a patient with chest pain and requests a cardiologist for cardiac evaluation. The ED services, observation E&M, observation facility code (G0378), and other services associated with the combined ED and ED observation care are coded on the ED SADR. What would the cardiologist code?

Clinical Pathway 2 Examples to Code

Length of Stay	99281 – 99285 Code E/M & all other codes associated with ED and OBS stay	99234 -99236 Admit/ Discharge same calendar day	99218 - 99220 Admit to OBS	99217 Discharge from OBS	99224 -99226 Subsequent interval day - OBS E/M	G0378 Facility OBS - per hour
1 Calendar Date- Admit & Discharge same day →						# _____
2 Calendar Dates-Discharge on Day 2 →						# _____
3 Calendar Dates- Discharge on Day 3 →						# _____

When OBS Status Converts to Inpatient

- "Clinical Pathway 3":
  - ED or Ward OBS status → Subsequently admitted as an inpatient
    - If admission subsequently occurs, the biggest change to this section of guidance is with the inpatient diagnosis code sequencing rule outlined in Section 9.2.
    - If inpatient admission occurs and the patient was in observation status in the ED, make sure to code and close out the "B" SADR with a Disposition Type of "Admitted."
    - If the same "observing" provider admits the patient, code the appropriate initial hospital admission E/M code for the day of admission and append modifier "-AI" (Principal Physician of Record) to the code (don't select an OBS E/M code).
    - Inpatient coders will identify original OBS services with subsequent admission and sequence V71.9 as the last-coded diagnosis on the SIDR; DRG will be based on the final code set.

Clinical Pathway 3 Coding Matrix

Length of Stay	99234 -99236 Admit/ Discharge same calendar day-OBS or IP E/M	99218 - 99220 Admit to OBS	99217 Discharge from OBS	99224 -99226 Subsequent interval day - OBS E/M	G0378 Facility OBS - per hour	V71.9 Sequenced last on the SIDR
1 Calendar Date- Admit & Discharge same day →					# ___	Yes
2 Calendar Dates- Discharge on Day 2 →					# ___	Yes
3 Calendar Dates- Discharge on Day 3 →					# ___	Yes

- Do not charge E/M codes in the "A" SADRs in for OBS services rendered prior to admission.
  - They accurately reflect the professional services provided to the patient.
- The ability to track and trend eventual inpatient admission that originated with observation status services is preserved when V71.9 is listed last in the SIDR diagnosis code set.

SADR Disposition Status

- Clinical Pathway 1: OBS on the Ward → to Home
  - The ED or clinic encounter preceding the order for Observation status should be coded and closed out with a Disposition Type of “Admitted” on the “B” SADR
  - The “A” Rounds SADR should use the status “Continued Stay”
- Clinical Pathway 2: OBS in the ED → to Home
  - No changes; close out the encounter as usual
- Clinical Pathway 3: OBS on Ward or in ED → Admitted
  - Close out the ED “B” SADR as “Admitted”
  - The “A” Rounds SADR should use the status “?”

Documentation Considerations

- These changes will likely require the establishment of Observation as part of operating guidance, standard protocols, and care paths.
- Physicians drive the entire process; education is vital
  - And documentation by nurses is crucial in determining total facility hours of OBS.
- Physicians need to justify clinical circumstances with clear, concise, convincing documentation
  - Medical necessity must be present

More Documentation Considerations

- The observation record for the patient must contain dated and timed physician's admitting orders regarding the care the patient is to receive while in observation, and progress notes prepared by the physician while the patient was in observation status. This information is in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.
- CPT and CMS both require the documentation of "timed entries documenting a patient reassessment throughout the observation period"
  - These reassessments should reflect that the physician
    - "Observed" the patient and checked on how they were feeling/what they were doing
    - "Has no more pain" or "sleeping soundly."

Sample OBS Documentation Template

EMA Observation Macro

Patient placed in observation status at *----------time----------+ for *---reason-observation--+. Initial assessment and exam completed. Previous medical records requested *------details/date-----+. Orders written.
Patient initially treated with *-----meds,_iv,nebs-----+ . Observed at bedside for initial response to treatment. Diagnostics reviewed. Patient re-evaluated every *--------one-two--------+ hour(s).
Ongoing treatment and assessment included *-----meds,_iv,_nebs----+ . Continued observation and assessment revealed *-exam/_lab/xray/observe+ .
*--Case_endorsed_to_Dr--+
Observation discharge examination of the patient revealed *--------findings-------+. Observation discharge care of the patient included a discussion of hospital stay versus outpatient management, instructions for continuing care, and preparation of the discharge records. Based on the patient's reassessment and response to treatment arrangements made for *---admxn/follow_up_on--+. Case *---discussed/_faxed---+ *---------doctor--------+. The patient remained under the direct care of an emergency physician for a total observation time of *--------number---------+ hours.

This template contains sentences with insert points that provide proper documentation of the required reassessments.

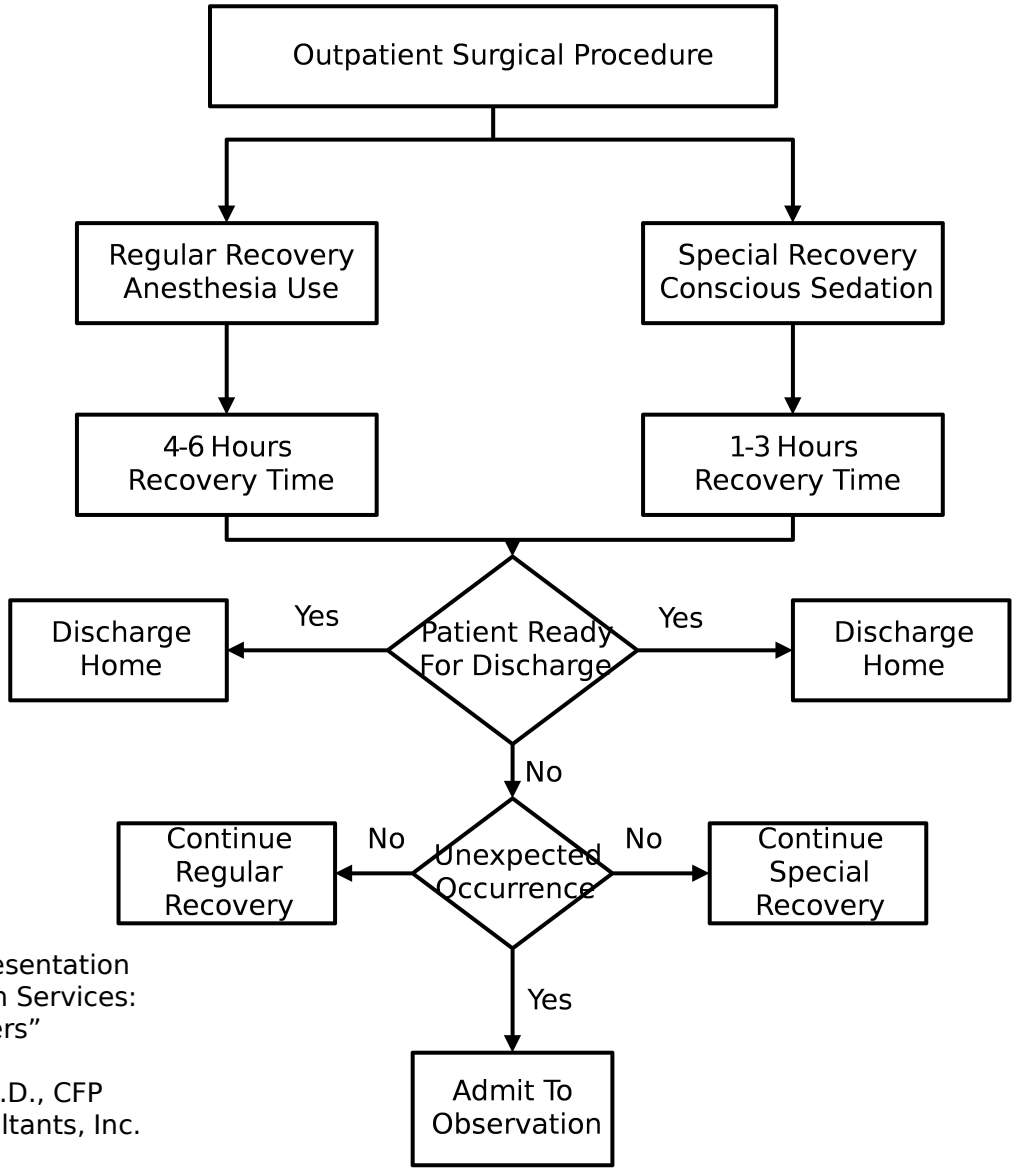
Source: http://www.alpha-apr.com/new-training-mods/Observation%20online%20coding%20presentation%20121707%20BA_files/frame.htm

Other Possible Intersecting Clinical Scenarios

- Inpatient Admission changed to OBS status
  - Patients should not be discharged from an inpatient admission to observation status except in rare and specific circumstances.
  - The provider must provide documentation outlining the circumstances surrounding any status change.
  - Such changes from inpatient to observation status cannot occur retroactively after the patient is discharged.
- If a patient in OBS status undergoes an ambulatory procedure via the APU, the SADR record for the observation status care is coded for the facility observation hours and provider professional services and closed out with disposition type of “Immediate Referral.”

APV Post-Operative OBS Scenario

- If patients in the APU have an unexpected occurrence, they can be moved to OBS status, and OBS protocols are followed



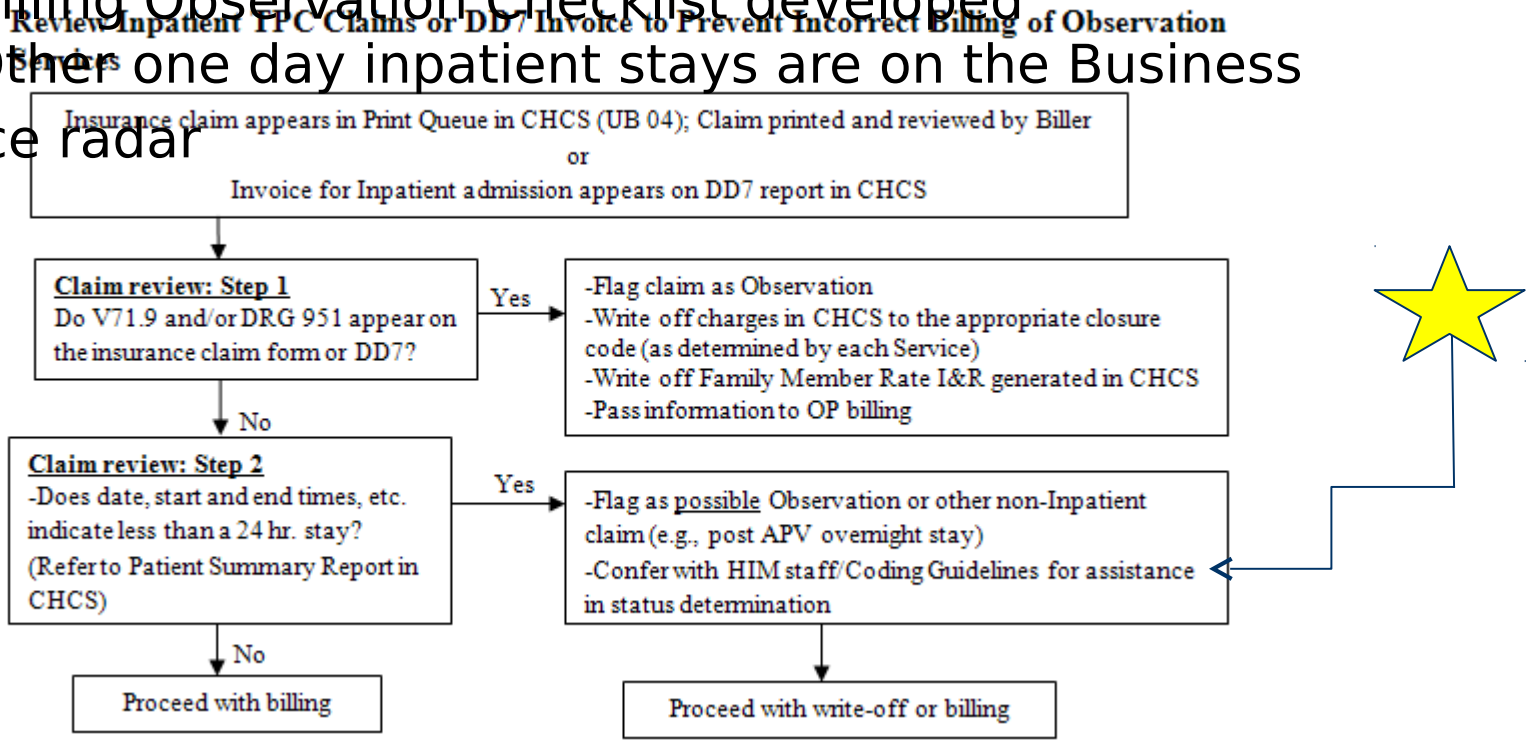
Source: PowerPoint Presentation
"Advanced Observation Services: Issues & Answers"
by
Duane C. Abbey, Ph.D., CFP
Abbey & Abbey, Consultants, Inc.
V9.6 – 2010
http://www.aaciweb.com

When Billing for OBS Occurs

- There are two primary objectives created with this observation policy change: to prevent improper inpatient facility billing of an outpatient service, and to bill payers and interagency partners appropriately for observation and other related services.
- Billing staff will need to monitor all system-generated inpatient claims/bills to identify those for patients in OBS status and cancel the incorrect inpatient claims/bills.
- They must then manually generate appropriate outpatient charges.

Coding and Billing Intersection

- Business Office staff will confer with Coding staff to
  obtain ADM/SADR "Rounds" data for OBS on the ward
  - ✓ Billing Observation Checklist developed
  - ✓ Other one day inpatient stays are on the Business Office radar



Summary

- This presentation concentrates on a number of special topics that relate to observation services.
- Because of the information systems architecture in the MHS, coded data separating IP vs. OP care is crucial.
- Observation services represent an ongoing challenge in which guidance will continue to morph over time.
- Whenever new policies are adopted or the UBU provides updated guidance, additional questions will be raised and addressed.
  - Please keep your UBU Service Manager informed of any OBS issues

Questions & Answers

- Questions?
- Answers?
  - Price quote:
    - Dumb looks are free
    - Right answers are $5.00
    - Wrong answers are $10.00